OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Dorothy Rae Skardoon**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1554/06(9)
DELIVERED ON:	25 May 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	3 April, 22 May 2007
FINDINGS OF:	Mr John Lock, Coroner
CATCHWORDS:	CORONERS: Inquest – Death following fall; recent eye procedure

REPRESENTATION:

Ms K Bryson of Counsel– appearing to assist the Coroner

Ms F Chapman, Solicitor, Sparke Helmore Lawyers – representing Dr J McCoombes;

Dr L Skardoon, self represented

Findings of the inquest into the death of
Dorothy Rae SKARDOON

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my findings in relation to the death of Dorothy Rae Skardoon. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

Introduction

At the time of her death, Dorothy Rae Skardoon was eighty-two years of age. She was discovered deceased in her residence by her daughter on 25 May 2006. On 24 May 2005, Mrs Skardoon attended a specialist medical appointment with an ophthalmologist. During the consultation, a procedure called a fluorescein angiogram was performed.

These findings seek to explain how the death occurred and consider whether Mrs Skardoon was appropriately managed by the relevant specialist.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

When Mrs Skardoon was located deceased, it was not apparent what had caused her death. As such, her death became a reportable death within the terms of the Act[1]. The matter was reported to police who in turn reported the death to the coroner for investigation and inquest.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [2]

[1] Section 8(3) (e) defines a death as reportable if a cause of death certificate has not been issued and is not likely to be issued for a person.

[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[3] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[4]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[5]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[8]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I will now say something about the investigation of Mrs Skardoon's death.

Following the discovery of Mrs Skardoon, the Queensland Ambulance Service attended along with the Queensland Police Service. Constable Bolgar stationed at the Indooroopilly Police Station was the officer tasked to investigate the death. Scenes of Crime officers also attended and photographs were taken.

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[3] s46

[4] s45(5) and 46(3)

[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

[7] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

[9] (1990) 65 ALJR 167 at 168

Mrs Skardoon was transported to the John Tonge Centre where an autopsy was performed by Dr Urankar the following day.

Staff of the Office of the State Coroner have also undertaken a number of inquiries and obtained statements. An expert report was also commissioned in order to examine the appropriateness, or otherwise, of the care provided to Mrs Skardoon by her treating specialist.

The inquest

A pre-hearing conference was held in Brisbane on 3 April 2007 before the Deputy State Coroner. Ms Bryson was appointed Counsel Assisting. Leave to appear was granted to Dr McCoombes and Dr Skardoon, the daughter of the deceased.

The inquest was heard on 22 May 2007. Two witnesses gave evidence, namely Constable Bolgar and Dr Skardoon. A total of thirteen exhibits were tendered. It was intended to hear from a further five witnesses.

After hearing from Dr Skardoon and for the reasons that will be referred to later in this decision, the court determined that it was not necessary to question or hear from other proposed witnesses and a determination could be made on the written statements.

The evidence

I turn now to the evidence. Of course I can not summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Family Background

Mrs Skardoon moved to Brisbane from Melbourne in about 1950. For her age, she was an active woman. She continued to live independently and drive a car up until her death.

Mrs Skardoon was an active member of her local community. She was a member of the National Seniors Committee, an active parishioner at her local Anglican Church and a member of a Probus club.

Medical history

Mrs Skardoon suffered from high blood pressure for which she had been medicated. Her prescription was ceased by her general practitioner in February 2005 as it was thought to be inducing hypotensive episodes.

Mrs Skardoon also suffered osteoporosis and Pagets disease for which she was medicated with aspirin daily and Actonel weekly. Both of these conditions have a negative impact on the structure and strength of a person's bones, predisposing a person to fractures from a fall or other trauma. Notwithstanding these conditions, Dr Skardoon said she was not often unwell and would not need to see doctors regularly.

Events of 24 May 2006

Mrs Skardoon was referred to Dr McCoombes, an ophthalmologist at the Eye Centre, River City on 24 May 2006 following a referral from Dr Watts and a diagnosis of

macular degeneration. Dr Skardoon had initially referred her mother to Dr Watts for a consultation. On 24 May 2006, Dr McCoombes performed a procedure called a fluorescein angiogram on Mrs Skardoon. A fluorescein angiogram is a type of test designed to provide information about the circulatory system and the condition of the back of the eye. The test is used to evaluate eye diseases that affect the retina and is performed by the injecting of the dye, Fluorescein, into a vein in the arm. The dye then travels to the blood vessels inside the eye and a camera photographs the dye as it travels through the blood vessels.

At the conclusion of the procedure, Belinda Castellano, Ophthalmic Technician, escorted Mrs Skardoon to the consulting room to allow Dr McCoombes to discuss the results of the test with her.

Dr McCoombes recalls discussing the findings of the fluorescein angiogram with Mrs Skardoon and observed that she was not experiencing any adverse reaction to the procedure. In his opinion, Mrs Skardoon was well. He accompanied her to the front counter so that a follow up appointment could be made.

Margaret Anderson, Medical Receptionist, made a follow up appointment for Mrs Skardoon and then called her a taxi. Ms Anderson recalls Mrs Skardoon exited the building via the front doors and waited to the left of the building until her taxi arrived. This was the last time Mrs Skardoon was seen alive.

The death is discovered

On 25 May 2006, Dr Skardoon attended her mother's residence at St Lucia. On arrival at the residence, Dr Skardoon noticed blood on the stairs and a trail to the bedroom where she found her mother laying on the floor deceased. Police were called and Constable Bolgar of the Indooroopilly Police Station attended the residence and commenced an investigation.

Autopsy evidence

An autopsy was conducted by Dr Urankar at the John Tonge Centre on 26 May 2006. Fractures were identified to the deceased's left tibia, left fibula at the ankle and left shoulder. It was concluded that the cause of death was haemorrhage due to a fracture caused by a fall. The autopsy also found that Mrs Skardoon was suffering mild coronary artery disease and valvular disease with a history of hypertension. Dr Urankar concluded that these three factors could have led to Mrs Skardoon experiencing left ventricular hypertrophy which may have caused an arrhythmia resulting in her falling.

During the autopsy, samples were taken and sent for toxicology testing. Those tests revealed alcohol in the urine at a rate of 60mg/100ml. It could not been determined whether Mrs Skardoon consumed alcohol prior to her death or whether the presence of alcohol was a post mortem reaction. In any event it is at a low level.

Expert evidence

An expert report was commissioned by an experienced Ophthalmologist; Dr Vandeleur Snr. Dr Vandeleur concluded the fluorescein angiogram was the appropriate investigative procedure to be undertaken given Mrs Skardoon's complaint. Further, he concluded that this procedure was carried out in accordance with best practice and made no criticism of Dr McCoombes' handling of Mrs Skardoon.

He also said the "*During a long experience doing fluorescein angiograms I have never seen normal vision worsened by the procedure. Dilating drops would have caused a temporary slight blur of vision. This recovers quickly and totally."*

Later in his report he said that "*I do not consider that Mrs Skardoon's death was caused by or contributed by either the side effects of the dilation drops or the fluorescein angiogram itself."*

Reasons for an Inquest

Dr Skardoon was very naturally concerned about the fact that her mother had clearly taken a fall on the stairs inside her dwelling on the very day of the eye procedure being performed. It is apparent that Mrs Skardoon fell down the first set of internal stairs to the landing and the serious fractures occurred. She very bravely pulled herself along and made her way up the stairs and a long a corridor to her bedroom. She reached her bed and then it seems collapsed on her floor where she was found by Dr Skardoon in what must have been a very distressing moment. There was a significant loss of blood and this all supports the autopsy findings as to the cause of death.

Dr Skardoon received a telephone call from her mother's home telephone late that afternoon but was unable to be connected. She may have made that call to her daughter after the fall and was unable to speak to her, although it is likely it was made earlier taking into account the lack of blood found on or near the telephone.

An eye procedure involving drops and injected dye would seem to most of us, to have the potential of side effects (such as blurring) which could have contributed to Mrs Skardoon's fall. Consequently, these matters needed to be investigated.

Mrs Skardoon was very independent and although her daughter was often involved in her medical treatment, this was not always the case. Dr Skardoon made the referral to Dr Watts but Mrs Skardoon appears on this occasion to have made the decision to have the procedure herself. Dr Skardoon was not aware of a diagnosis of macular degeneration until she read the subsequent report from Dr Watts.

Dr Skardoon gave evidence of some communication difficulties she had with Dr McCoombes and his associates but these are not issues directly related to matters the Coroner can comment on. She was concerned with post treatment care and possible negligence involving the fluorescein angiogram which clearly are matters the Coroner should be concerned about.

The report of Dr Vandeleur was not made available until a few days prior to the inquest. As the record will show, Dr Skardoon accepted he was a highly regarded specialist in his field and unreservedly accepted his report. She advised the Court that

in that event she had no questions for him or for other witnesses who were to be called.

The Court considered that, in the light of this proper and no doubt well considered concession and taking into account the issues that needed to be determined, there was no need to question other witnesses or hear other evidence and the inquest could be determined on the written statements and evidence as it stood.

Mrs Skardoon has clearly fallen at her home. She had some predisposition to fractures as a result of osteoporosis and Paget's Disease. She suffered very serious fractures of her left ankle in particular which, due to the extensive loss of blood, caused her death. Why she fell cannot be established. Her underlying heart condition may have led to an arrhythmia initially causing the fall. It may have been just a tragic accident. What can be ruled out is that the fluorescein angiogram caused blurring or poor vision as it is clear on the evidence and the opinion of Dr Vandeleur that on her leaving the eye centre her vision would have returned to normal.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where she died, what caused the death and how she came by her death. I have described above my findings in relation to this last aspect of the matter. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other particulars of the death.

Identity of the deceased	The deceased person was Dorothy Rae Skardoon
Place of death	She died in St Lucia, Brisbane
Date of death	She died on or about 24 May 2006
Cause of death	Haemorrhage as a consequence of a compound fracture to the left ankle as a consequence of a fall down stairs.

Concerns, comments and recommendations

Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The circumstances of Mrs Skardoon's death, in my view, do not raise any further issues for consideration.

I close the inquest.

John Lock
Coroner
Brisbane
25 May 2007